DANISH HEALTH AUTHORITY

NATIONAL CLINICAL GUIDELINE ON URINARY INCONTINENCE IN WOMEN

Quick guide

Consider offering supervised pelvic floor muscle training to women with urinary incontinence

Weak recommendation

The recommendation was updated without changes in 2019

Pelvic floor muscle training requires considerable and persistent efforts from the woman, and the woman's motivation for training should be clarified before supervised training is offered.

Supervised pelvic floor training can be performed as individual training or group training by a professional with relevant competences (e.g. a doctor or a physiotherapist), but should, as a minimum, include two individual assessments with palpation and assessment of whether the woman can perform a correct pelvic floor muscle contraction as well as instruction in how to perform the exercises correctly. The overall duration of the training intervention should be minimum three months, followed by a planned evaluation of the treatment efficacy and consideration of further treatment.

The training should be organised in accordance with general physiological principles to ensure a sufficient degree of overload and progression. The training should be organised so that muscular strength, static and dynamic endurance as well as coordination are all targeted. The training should be progressive in relation to the progress made.
The woman should train on her own at least 3-4 times a week, preferably daily.

Bladder training as monotherapy should only be offered to women with urgency urinary incontinence after careful consideration, as the beneficial effect is uncertain.

Weak recommendation **AGAINST**

It was not considered necessary to update the recommendation in 2019

Bladder training may be considered as a supplement to pharmacological treatment with an antimuscarinic or a beta3-agonist for women with urgency urinary incontinence.

As part of the assessment and treatment of women with urgency urinary incontinence, a frequency-volume chart can be used to monitor voiding frequency, fluid intake, 24-hour diuresis, voiding intervals and bladder capacity.

Consider offering treatment with a incontinence ring or incontinence tampon to women with urinary incontinence.

Weak recommendation

It was not considered necessary to update the recommendation in 2019.

It may, in particular, be relevant to offer treatment with incontinence ring or incontinence tampon to women who either do not want surgical treatment or where surgical treatment is not possible.

Treatment with incontinence ring or incontinence tampon can be offered to women who experience incontinence only in connection with special activities, such as sports activities, and who are not immediately interested in surgery.

Treatment with incontinence ring can be offered to women who are waiting for incontinence surgery.

Vaginal oestrogen therapy should be considered for postmenopausal women with an incontinence ring to strengthen the vaginal mucosa and reduce the risk of pressure discomfort.

Prescription and testing of an incontinence ring, including the choice of type and size of the pessary, should be done by a healthcare professional with experience and relevant competences in this. The woman should be instructed in correct use and eventually change of the pessasy if required. Treatment efficacy should be evaluated after 1-3 months.

It is good practice to offer basic assessment to women with urinary incontinence and impaired cognitive functions. Further assessment ought to be based on the individual patient's condition, taking into consideration the expected benefit of potential interventions.

Good practice

It was not considered necessary to update the recommendation in 2019

Further assessment should always be carefully considered in relation to conditions for which the intervention will be pelvic floor muscle training or surgery if it is found that the woman will not be able to participate in training or postoperative restrictions. In such cases, it may be considered whether technical aids, for example incontinence pads or catheterisation (pure intermittent catheterisation, suprapubic catheter, transurethral catheter), may be a more suitable solution. In women with impaired cognitive function and urinary incontinence, toileting on a fixed schedule may be a relevant healthcare intervention

Basic evaluation ought to include frequency-volume chart, anamnestic information about macroscopic haematuria, urine culture if there are symptoms of cystitis in addition to incontinence and constipation, and examination for residual urine with ultrasound, single catheterisation or (if there is no other option) bladder palpation. It may be considered whether treatment of one or more contributory or aggravating conditions such as constipation may benefit the woman. Attention should also be paid to inappropriately fluid intake and voiding habits, for example by using a frequency volume chart.

Use of medication may always be considered, as certain preparations may aggravate urinary incontinence.

Consider offering a supervised weight loss plan to severely obese women with stress urinary incontinence.

Weak recommendation

It was not considered necessary to update the recommendation in 2019

A relative weight loss of 10% in even severely obese women will in most women reduce the degree of stress urinary incontinence.

In a weight loss program involving physical training and exercise, it is important to pay attention to the function of the pelvic floor muscles and possibly provide parallel training of the pelvic floor muscles. In some obese women, a weight loss may consciously or unconsciously lead to an increased activity level, resulting in unchanged or increased discomfort from stress urinary incontinence.

A weight loss program is a time-consuming treatment, and completion of the program requires great motivation.

Consider offering supervised pelvic floor muscle training to women with stress urinary incontinence prior to any midurethral sling surgery.

Weak recommendation

It was not considered necessary to update the recommendation in 2019

Pelvic floor muscle training requires considerable and persistent efforts from the woman, and the woman's motivation for training should be clarified.

When recommending pelvic floor muscle training, the woman's pelvic floor muscle function and muscle strength ought to be taken into consideration prior to referral to supervised pelvic floor muscle training in relation to assess the need for individual supervision or group training. The woman's motivation for pelvic floor muscle training must also be established, as motivation is a precondition for a good result. Overall duration of the training intervention ought to be minimum three months followed by planned evaluation of the achieved effect and consideration of further treatment.

Consider offering midurethral sling surgery to severely obese women with stress urinary incontinence on the same terms as for women of normal weight.

Weak recommendation

It was not considered necessary to update the recommendation in 2019

Prior to surgery, weight loss ought to be considered as a supplement or alternative to surgery. Severely obese women (BMI >30) do not need to achieve normal weight (BMI<25) to have a beneficial effect of pelvic floor muscle training on stress urinary incontinence. In most women, a relative weight loss of 10% will reduce the degree of stress incontinence. A supervised weight loss programme may be considered in the motivated woman.

Pelvic floor muscle training ought also to be considered prior to surgery. The woman's motivation for pelvic floor muscle training must be established, as motivation is a precondition for a good result.

Treatment with incontinence ring may be tried prior to or during the waiting period before incontinence surgery.

Retropubic midurethral sling (MUS-RP) rather than transobturator midurethral sling (MUS-TO) should be offered to women with stress urinary incontinence and indication for surgical treatment.

Strong recommendation

The recommendation has been updated and amended in 2019

If MUS-RP is not possible for technical surgical reasons, e.g. in case of severe obesity, previous infection, surgery or adherences, other treatment options, including MUS-TO, may be considered.

Vaginal oestrogen supplement should not be used as an add-on to antimuscarinic/beta3-agonist treatment on a routine basis in women with urgency urinary incontinence for this indication.

Weak recommendation **AGAINST**

It was not considered necessary to update the recommendation in 2019

Vaginal oestrogen supplement may be considered as an add-on to antimuscarinic/beta3-agonist treatment in urgency urinary incontinence and concurrent urogenital discomfort from mucosal atrophy.

Treatment with vaginal oestrogen supplement may be indicated for other urogenital consequences in postmenopausal women, such as recurrent cystitis, vaginal dryness, dysuria and burning sensation around urethra and introitus.

There are various dispensing forms of vaginal oestrogen, which is dosed in accordance with the summary of product characteristics. Creams and suppositories are applied twice weekly as maintenance dose, and a vaginal insert (hormone ring) is applied deep inside the vagina, worn continuously for three months and replaced with a new one.
The woman's preferences must be established.

Consider treatment with a beta3-agonist or an antimuscarinic in women with urgency urinary incontinence. There is no documentation of clinically relevant differences.

Weak recommendation

It was not considered necessary to update the recommendation in 2019.

Treatment efficacy and adverse reactions should be assessed after four weeks of treatment. In case of beneficial effect and tolerable adverse reactions, the chosen treatment is continued. It may be considered suspending treatment for approximately three weeks a year to assess the continued need.

Pharmaceutical interactions must always be considered when prescribing medication to women who are already taking many other medicines. Here it may be useful to consult the Danish Health Authority's online tool www.interaktionsdatabasen.dk (in Danish).

When prescribing medication to elderly women, potential adverse reactions in the central nervous system such as headache, dizziness, impaired cognitive function and confusion may also be considered when choosing preparation.

As beta3-agonists are currently significantly more expensive than most antimuscarinics, the Danish Health Authority recommends choosing an antimuscarinic as first choice, depending on the current price. In case of dry mouth discomfort, a switch to another antimuscarinergic or beta3-agonist is recommended.

DANISH HEALTH AUTHORITY

About the quick guide

This quick guide contains the key recommendations from the national clinical guideline on urinary incontinence in women. The guideline was prepared under the auspices of the Danish Health Authority.

The national clinical guideline focuses on assessment and treatment of women with urinary incontinence. The guideline includes recommendations on pelvic floor muscle training, bladder training, weight loss programme, use of vaginal aids, as well as medical and surgical treatment of urinary incontinence in women. The guideline also includes a recommendation on assessment and treatment of women with impaired cognitive functions and urinary incontinence.

The national clinical guideline contains recommendations regarding selected parts of the field, and it cannot stand alone, but must be seen in conjunction with other guidelines, recommendations, process descriptions etc. in this field.

Further information at www.sst.dk
At the Danish Health Authority's website (www.sst.dk), a full-length version of the national clinical guideline is available, including a detailed review of the underlying evidence for the recommendations.

About the national clinical guidelines
The national clinical guideline is one of the national clinical guidelines to be prepared by the Danish Health Authority during the period 2017-2020.

Further information about the choice of subjects, method and process is available at www.sst.dk